

Iowa Department of Human Services



State Innovation Model Test *Appendix D: HIT Enhancement Planning*

March 2017

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Operational Plan Purpose

Iowa recognizes the need to create a framework to support the move from volume to value, as well as the need to establish information management protocols. Iowa's goal is to develop and implement the necessary technology and infrastructure to integrate clinical and claims data to promote the exchange of information to improve service delivery. Plans for integrating data from external providers, such as electronic medical record (EMR) data and hospital discharge data, using health information technology (HIT), health information exchange (HIE), and Electronic Health Records (EHR) capabilities are being specifically explored. Multi-Stakeholder Engagement Groups are currently being established as a first step in developing an understanding of the need for additional HIT infrastructure and the glide path necessary for Iowa. The state expects to finalize specific plans for an achievable, workable solution within the coming months.

This document is intended to inform readers, including reviewers from the federal Centers for Medicare and Medicaid Services (CMS), of how Iowa intends to utilize State Innovation Model (SIM) grant funds to support improvements in the state's health care system. The Introduction of MACRA during the SIM grant and the final rules released in October has caused Iowa to pause to review, and vet the impact and opportunities. This has led to many hours in developing an Iowa SIM Year 3 approach that is aligned and complementary to the goals of CMS. Iowa has many of the pieces needed to develop quality framework around population health improvement and payment reform but, recognizes the need to organize and build upon those pieces to reach our goals.

Current Health IT Infrastructure

The initial approach is to leverage current infrastructure, as a starting point, with the intention of expanding infrastructure that will build a path towards transformation that supports both delivery system and payment reform initiatives. Iowa recognizes the long term potential of other data to inform quality including Social Determinants of Health and strong integration of community resources. The Figures 1 & 2 below describe the current Health IT Landscape in Iowa.

Figure 1: Current Health IT Landscape at the Provider, Payer, and State Level

Current State					
Health IT functionality	Information Purpose & Location	Long Term Barriers	Funding	Policy Levers Utilized	Implementation Date
Reporting Services					
Analytic Services	3M The IME's analytic vendor, 3M, provides analytic services on claims and encounter data to produce a quality improvement score used for VBP incentives. Wellmark also uses 3M Analytics to produce quality improvement scores for their participating providers. 3M also provides analytics of Assess My Health member responses	3M provides analytics relevant to claims based measures, the ability to satisfy all of the goals and objectives of MACRA QPP are not clear. Not all providers are engaged in using a standardized HRA	SIM	The Medicaid contracts with the MCO's require the use of 3M Analytics as a tool to inform VBP Contracting in Iowa. Iowa's other largest payer Wellmark also uses 3M for analytics. Payer alignment reduces undue burden on providers. The state has plans to implement contract requirements to use AMH as the standardized HRA tool within VBP Contracts.	The IME has used 3M for claims based quality metric analytics since 2014 Wellmark has used 3M for claims based quality metric analytics since 2012. July 2017
	CHIME MAPS Web-based population health and geographic mapping program that provides for hospital market analysis and community needs assessment incorporating IHA Iowa hospital discharge, population health and demographic data. Hospitals use this program to help develop process improvement strategies with community coalitions; IHC guides the use of the program through Technical Assistance.		SIM (through contract with IHC) & Iowa Hospital Association		

Health IT functionality	Information Purpose & Location	Long Term Barriers	Funding	Policy Levers Utilized	Implementation Date
Notification Services	Statewide Alert Notification System (SWAN)	<p>Current marketplace for using ADT data is Immature.</p> <p>Practice model for use in a rural setting has not yet been developed</p> <p>Funding beyond SIM – Pricing Model / Return on Investment</p>	SIM (funding provided for alerts on the Medicaid population only)	Same day notifications of inpatient hospital stays is a requirement outlined in the RFP for the MCOs	SWAN has been operational since December 2015
	Wellmark Notifications to ACO providers Weekly report to ACO providers listing inpatient hospitalizations.	<p>Wellmark Proprietary Inpatient Reporting Process</p> <p>Requires compliance with Wellmark reporting requirements for each hospital.</p>	Wellmark		Wellmark implemented this process in 2012
Exchange Services	Iowa Health Information Network (Direct Secure Messaging, Query)	<p>Federated model, is not currently set up for analytic reporting</p> <p>Full potential for providers to use has not yet be realized.</p>	Payer (Medicaid) Provider	Implemented as Statewide Infrastructure House file 381	Services of the IHIN became functional in 2012. In March 2017 the IHIN will transition from a state run entity to a non-profit.

Health IT functionality	Information Purpose & Location	Long Term Barriers	Funding	Policy Levers Utilized	Implementation Date
Consumer Tools	Health Risk Assessment (HRA)	<p>The lack of a standardized tool for direct service providers has resulted in inconsistent connections between patient and providers.</p> <p>And inadequate collection of information related to social needs in individual and aggregated form.</p>	SIM (Assess My Health)	<p>MCOs are required as part of their contract with the state to complete HRAs on all newly enrolled members within 90 days of enrollment.</p> <p>Requirement of the Healthy Behaviors Program for the expansion population requires the completion of an annual HRA.</p>	The IME began using the Assess My Health HRA in 2014. Since the implementation of Managed Care additional HRAs are being used specific to each MCO.
	Member Portals	<p>Not connected statewide</p> <p>Patient information is only unique to claims submitted to a particular payer or services rendered through a particular health system</p>	Varied (not SIM)	unknown	varied
	Wellmark Public Provider Star rating <p>Members are able to see VIS calculated quality score (1- 5) of a provider on the Wellmark website</p>		Wellmark		Wellmark began publishing the Star rating in January 2017

Health IT functionality	Information Purpose & Location	Long Term Barriers	Funding	Policy Levers Utilized	Implementation Date
Provider Tools	3M Value Index Score (VIS) – Quality Metrics Dashboard A quality improvement score is available to providers / organizations through an online dashboard that is derived from claims based quality measures. Wellmark also uses the VIS to track quality improvement scores for participating providers in the Wellmark ACO program	3M provides a quality improvement score that is derived from claims based measures Providers struggle with linking their quality score to clinical quality improvement activities.	SIM for Medicaid Wellmark for Wellmark	Medicaid contract with the Managed Care Organizations requires the use of 3M Analytics as a tool to inform VBP Contracting in Iowa. Iowa's other largest payer Wellmark also uses 3M for analytics with their ACO contract. Payer alignment reduces undue burden on providers.	The IME began using the VIS as a Metric reporting tool in 2014 with the Iowa Medicaid Expansion population "Iowa Health & Wellness". Wellmark began using the VIS as a Metric reporting tool in 2012 with their ACO Participating Providers.
	Provider Incentive Payment Portal (PIPP) – Meaningful Use Reporting System PIPP is the State Level Repository (SLR) developed to allow Medicaid Providers to log into a secure web based system to attest to Meaningful Use including manual reporting of aggregate clinical quality measures as required by the EHR Incentive Meaningful Use Program	This tool was solely designed as an attestation portal for the EHR Incentive Program; it was not developed with the intention of being a reporting mechanism and lacks the capability to report data that would be useful in VBP.	HITECH	Iowa Administrative Code requires that providers attesting for the Medicaid EHR Incentive Program use PIPP and abide by all terms and conditions associated with the incentive program.	The Provider Incentive Payment Portal (PIPP) became operational in April 2012. EHR attestations prior to this date were collected through another mechanism.

Health IT functionality	Information Purpose & Location	Long Term Barriers	Funding	Policy Levers Utilized	Implementation Date
Provider Tools cont....	In Patient Out Patient (IPOP) Statewide Inpatient Database that contains patient-level discharge data for all acute discharges including newborns from Iowa community hospitals	Dependent on consistent hospital reporting	IHC; CMS (HIIN)	unknown	The IHA Statewide Outpatient Database contains all hospital outpatient visits beginning in 2004 and a subset of hospital and outpatient procedures from Iowa hospitals from prior years back to 1995. Data is submitted from Iowa hospitals quarterly and readmissions aggregated by hospitals by month is provided to IHC and used in the SIM Portal to develop community scorecards.
	Electronic Lab Reporting (ELR) Reportable lab results are transmitted from connected providers EHR to the IHIN.				
	Immunization Registry (IRIS) Iowa's Immunization Registry Information System (IRIS) provides computerized tracking of immunizations for children, adolescents and adults throughout the state.				

Health IT functionality	Information Purpose & Location	Long Term Barriers	Funding	Policy Levers Utilized	Implementation Date
Provider Tools cont....	Iowa HealthCare Collaborative (IHC) Community Scorecard Developed to drive quality improvement at the community (C3) level. Data is collected through the IHC SIM Portal and IDPH. Clinic NQF measures; SIM Community process and outcome measures; HIIN Hospital Data; IDPH SDH, measures are aggregated by community and displayed on the scorecard.	Manual collection of NQF Measure The Scorecard is only for SIM (C3) participants.	SIM		Scorecards will be distributed quarterly to C3s, starting March 2017.
	Cancer Registry Population-based cancer registry that has served the State of Iowa since 1973.		National Cancer Institute, National Institute of Health, DHS(F)(S), University of Iowa		Implemented in 1973, Electronic reporting capability with CEHRT through IHIN.

Health IT functionality	Information Purpose & Location	Long Term Barriers	Funding	Policy Levers Utilized	Implementation Date
Provider Tools cont....	Electronic Health Records (EHR)	<p>EHR systems are limited by the functionality that the provider/ organization purchased.</p> <p>New certification requirements will enhance the functionality of EHRs but the requirement on the provider to utilize/update their system is not until 2018</p>	Providers Purchase their own EHR	The HITECH Act and ONC have set specific certification standards to ensure that EHRs will have the capability to be used Meaningfully to inform HealthCare Quality and performance improvement.	Providers began using EHRs at various times throughout the state. Iowa has a high EHR adoption and use rate with over 4000 unique payments going to providers and hospitals who attested to AIU since 2011. And over 3500 unique payments going to providers and hospitals who have attested to years 2-5 for Meaningful Use.
Patient Attribution	3M – PCP Assignment or Plurality of Visits <p>Methodology is updated monthly on a rolling basis.</p> <p>Members are attributed to Medicaid enrolled PCPs. The methodology allows the member to choose or be assigned a PCP (through a process defined by their assigned MCO). If a member does not have an assigned PCP, then the member is attributed using a methodology based on counting unique E/M visits In this case the member is assigned to the provider with the highest number of unique visits.</p>		SIM	Medicaid requires the MCOs assign members to PCPs upon enrollment to their plan.	<p>The IME adopted this methodology with the implementation of VBP in 2014 with the Iowa Medicaid Expansion population “Iowa Health & Wellness”.</p> <p>Wellmark began using this methodology in 2012 with their ACO Participating Providers.</p>

The diagram illustrates the 'Current State: Health IT Landscape' with the following components and processes:

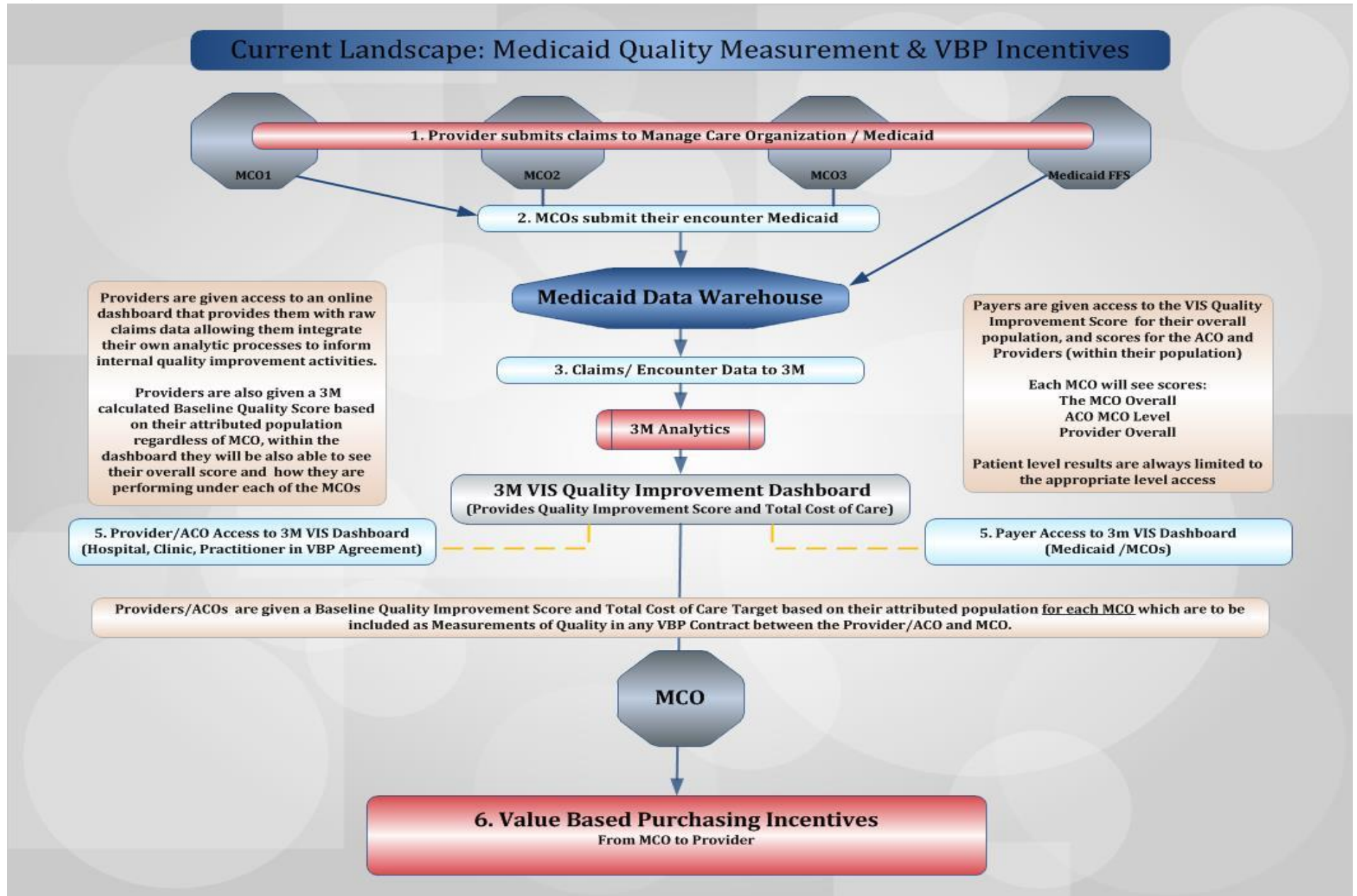
- Entities and Data Stores:**
 - START: Member** (Yellow rounded rectangle)
 - Hospital** (Blue rounded rectangle)
 - Clinic** (Blue rounded rectangle)
 - C3** (Pink hexagon)
 - TA** (Grey star)
 - SIM Portal** (Green cylinder)
 - VIS 3M Analytics** (Red cylinder)
 - PIPP EHR Incentive / Meaningful Use Attestation Portal** (Red rounded rectangle)
 - NLR Meaningful Use** (Red trapezoid)
 - IHIN** (Blue circle containing **QUERY**, **DIRECT**, and **SWAN (Alert)**)
 - SWAN (Alert)** (Blue circle)
 - ACO** (Orange rounded rectangle)
 - MCO** (Orange rounded rectangle)
- Processes and Data Flows:**
 - 1. Event**: From **START: Member** to **Hospital**.
 - 2. Hospital may query the IHIN to obtain information regarding the members health conditions**: From **Hospital** to **QUERY**.
 - 3. Member event generates an ADT that is sent to the IHIN**: From **Hospital** to **IHIN**.
 - 4. SWAN may generate an alert for both the ACO and MCO if the member is on the designated entities SWAN eligibility List**: From **IHIN** to **SWAN (Alert)**, which then flows to **ACO** and **MCO**.
 - 5. ACO Forwards Alert to Clinic/ Provider based on Internal Processes**: From **ACO** to **Clinic**.
 - 6. Clinic may query the IHIN to obtain more specific information regarding the members event**: From **Clinic** to **QUERY**.
 - 7. Clinic closes the loop by referring the member as necessary for additional services identified during its Post Alert Follow Up/Care Coordination process**: From **Clinic** to **START: Member**.
 - 8. A clinic may make a referral to a C3 Community may be made if they identify additional needs for the member**: From **Clinic** to **C3**.
 - 9. The C3 Community will close the loop by reaching out to the member and working them to ensure that additional needs are being addressed**: From **C3** to **START: Member**.
 - 7. MCO will close the loop by referring the member as necessary for additional services identified during their Alert follow up procedures**: From **MCO** to **START: Member**.
 - 5. MCO may query the IHIN to obtain more specific information regarding the members event**: From **MCO** to **QUERY**.
 - 6. MCO conducts Post Alert Follow Up/ Care Coordination based on its internal processes or requirements**: From **MCO** to **START: Member**.
- Data and Reporting Flows:**
 - HIIN Data**: A vertical label on the left side of the diagram.
 - NQF Measures**: A label on a line connecting **Clinic** to **SIM Portal**.
 - 3M Potentially Preventable Data**: A label on a line connecting **SIM Portal** to **VIS 3M Analytics**.
 - Meaningful Use data is automatically sent electronically to the NLR**: A label on a line connecting **PIPP** to **NLR Meaningful Use**.
 - Providers attest to Meaningful Use by logging into a web based portal and entering their attestation information**: A label on a line connecting **PIPP** to **PIPP**.

Measurement of Quality

Current State

Iowa uses an analytic vendor, 3M, to provide analytics and develop quality improvement scores utilizing claims and encounter data. Figure 3 below outlines the process in which Medicaid providers submit and get paid for services from the Managed Care Organizations or Medicaid. Every month each MCO submits an encounter file to the Medicaid Data Warehouse that is then combined with any Medicaid Fee for Service data where it is validated to ensure that it had the components necessary for 3M. After completion of the validation process the entire set of data is sent to 3M for analytic processing. 3M completes an additional validation process including attributing members to the Primary Care Provider and MCO of assignment, formulate a set of expected and risk adjusts all appropriate measures. Upon completion of their analytic and validation process a **VIS Quality Improvement Score** and **Total Cost of Care Target** is generated at the ACO/Provider level based on their attributed population for each MCO.

Figure 3: Medicaid Quality Measurement & VBP Incentives



Iowa Medicaid and the MCOs are working together to align Value Based Purchasing (VBP) strategies that are designed to transform the healthcare delivery system in order to both improve population health outcomes and bend the cost curve for health services to a level that is sustainable for the state.

For an MCO to qualify toward their requirements to get 40% of covered lives in VBP, each of their VBP contracts must include the use of the state defined set of risk adjusted quality measures, Value Index Score (VIS) and Total Cost of Care (TCOC) Methodology.

The VIS is an enterprise tool for measuring health system change and the components necessary for that change. It produces a single, holistic, composite score that quantifies how well a provider takes care of his or her entire patient population within a system of care, based upon 6 critical primary care domains. These 6 domains derive from 16 measures of key processes and outcomes that lead to value in healthcare. Figure 4 provides a comprehensive look into each of the domains and measures used to calculate a quality improvement score.

Figure 4: VIS Quality Domains

VIS Domain – Primary & Secondary Prevention (Adult Screenings, Well Exams)

This domain measures the provider's performance on screening services designed for early detection or prevention of disease. These measures are similar to the National Committee for Quality Assurance's (NCQA) Health care Effectiveness Data and Information Set (HEDIS), a tool used by more than 90 percent of America's health plans to measure performance.

The primary prevention domain includes scores for:

- Percent of the provider's pediatric well-visits for children birth to 15 months, and three years to six years
- Percent of the provider's mammogram screening to applicable patient populations
- Percent of the provider's colorectal cancer screening to eligible patient population

First Contact with Health Care System

VIS Domain – Tertiary Prevention (Ambulatory Care Sensitive Acute and ED rates)

In addition to primary and secondary prevention to help keep the population healthy, the 3M Value Index Score has a Tertiary Prevention Domain that evaluates the effectiveness of a provider in addressing "sick" care. This domain incorporates two measures: potentially preventable hospital admissions and hospital emergency room visits.

The tertiary prevention domain includes:

- Percent difference between the expected number of hospital admissions that are potentially preventable and the actual rate of the provider's population
- Percent difference between the expected number of hospital emergency room visits that are potentially preventable and the rate of the provider's population

Comprehensive

VIS Domain – Panel Health Status Change (Disease Progression)

One measure for determining providers' ability to deliver quality care is their ability to manage the health status of their patient panel from one time period to another. This domain of the 3M Value Index Score uses a risk-adjusted assessment of the percent difference between the expected rate of disease progression and the actual rate of the disease progression in the provider's patient panel. The population health status domain uses two metrics of disease progression:

- Change in the number of chronic conditions
- Change in the severity within the chronic conditions

VIS Domain – Chronic & Follow-up (30 day post D/C, Readmission Rates, Chronic Care Visits)

For members of the population who have chronic conditions, the 3M Value Index measures the processes and impact chronic and follow-up care.

The chronic and follow-up care domain includes the following three measures:

- Percent difference between the number of expected hospital readmissions that are potentially preventable and the provider's actual number of potentially preventable readmissions
- Percent of the provider's panel that visited a physician office within 30 days post-discharge for acute admissions outside of an uncomplicated delivery and 45 days for an uncomplicated delivery
- Percent of the provider's panel with chronic disease that have three or more physician visits

Coordinates Care and the Transfer of Information

VIS Domain – Continuity (COC Index, PCP Visit, Any MD Visits)

This domain measures the concentration and continuity of physician visits. The Continuity Domain is associated with a number of positive outcomes, such as lower rates of hospitalization and readmissions, more efficient medical care, and higher patient satisfaction.

- Specifically, the continuity domain includes:
 - Percent difference between the expected continuity of care index for providers serving similar populations and the actual score for the provider's panel (as published by Bice, T. W., & Boxerman, s. b. (1977). a quantitative measure of continuity of care. Medical care, 15(4), 347-349)
 - Percent of the provider's panel visiting a primary care provider (PCP)
 - Percent of provider's panel that visit a physician during evaluation year

VIS Domain – Efficiency (Generic Rx, Potentially Preventable Ancillaries)

The Efficiency Domain examines the risk-adjusted rate of prescribing generic medications and the appropriate use of outpatient services for a physician's panel. The analysis of outpatient services examines potentially preventable ancillary services, such as high cost imaging, ordered by primary care physicians or specialists that may not typically provide useful information for diagnosis and treatment.

- Specifically, the efficiency domain examines:
 - Percent difference between a physician's risk-adjusted performance on potentially preventable services and the expected rate for a comparable population
 - Percent difference between a physician's risk-adjusted rate of prescribing generic drugs and the expected rate for a comparable population

Future State

To achieve an A-APM model in Iowa, the collection of clinical quality measures (in addition to the administrative measures from VIS), is a new consideration of the Iowa definition of quality. The state is in the early planning stages to identify infrastructure and measures that are comparable to MACRA QPP to be used in an Other Payer A-APM model to support future programs within Iowa.

Iowa's goal during Award Year 3 of SIM is to plan, develop, and implement the necessary technology and infrastructure to promote the exchange of information to improve service delivery.

Iowa will conduct a Provider Readiness and Health IT Infrastructure survey to obtain a true picture of what capabilities and gaps may exist in Iowa. The results of the survey should help us plan solutions that clearly outline our value propositions and the next steps for implementation.

Focus areas for the Provider Readiness survey include:

- Provider EHR Certifications & Capabilities
- Barriers to Data Extraction from EHRs
- Financial Barriers
- Workflow Barriers
- IHIN Adoption Rates
- Core Clinical Quality Measures that should be included

Focus areas for the Health IT Infrastructure survey include:

- Assessment of the current technical infrastructure available in Iowa
 - Data Collection ability
 - Data Aggregation ability
 - Analytics
 - Reporting Services
- Financing
- Governance
- Sustainably

SIM Goal: Mature the Infrastructure & Use of Health IT Analytics to Support VBP

SIM Goal:	
Mature the Infrastructure and Use of Health IT and Analytics to Support VBP	
Start date: 01/01/2017	
End date: 12/31/2020	
Barriers to achieving this goal: Un-Clear definition of true overarching needs and method of approach	
Mitigation: Develop a common platform of terminology and consensus on state level needs.	
Levers in Place to help SIM achieve this Goal:	
The following AY 3 activities will support SIM in achieving this goal:	How
Develop workgroups Roles & Responsibilities	SIM Team with by in from SIM Leadership will develop work groups that will meet regularly to formulate the plan for long term goals for Health IT Infrastructure in Iowa. For example: Quality Measurement; Health IT; Payment Reform etc.
Conduct a provider readiness survey	The SIM Team will conduct a provider readiness survey with Iowa's Health Systems to assess their capability for collecting and submitting CQM data. This survey will also asses the perceived demand for a centralized reporting mechanism. Findings from this analysis will define the next steps for implementation of any needed infrastructure to collect CQMs.
Determine need for NEW or re-purposed infrastructure (and financing) to support VBP	The SIM Team will conduct a statewide assessment of current available Health IT infrastructure to determine: <ol style="list-style-type: none"> 1. If there is an ability to re-purpose existing elements capable of reporting of Clinical Quality Measures to support an A-APM in Iowa, including the potential for IHIN functionality expansion under the new entity. 2. If there is a need for new to support reporting of Clinical Quality Measures to support an A-APM in Iowa. 3. What financing mechanisms exist to support actions 1 & 2 above.
Educate Iowa providers, payers and other stakeholders on the "WHY" infrastructure is needed to support VBP (MACRA).	The SIM team will convey a common platform for HIT VBP through the use of Webinars, Statewide Learning Events, and Website updates etc.

SIM Goal: Establish a Glide Path to Incorporate Clinical Data into VBP and an APM Model

SIM Goal:	
Establish a glide path to incorporate clinical data into VBP and an APM model	
Start date: 01/01/2017	
End date: 01/01/2019	
Barriers to achieving this goal: Payers feel CQMs are disease specific and not population health specific and providers do not agree on the right CQM to reflect system quality.	
Mitigation: Begin with C3 regions and Medicaid only then move to full reporting across the state	
Levers in Place to help SIM achieve this Goal:	
AY 3 activities that will support SIM in achieving this goal:	How
Develop and use a common definition of Quality Measurement	The SIM team will educate and engage MCOs to work together in development and use of a common definition of quality measurement for VBP Contracting.
Develop a Pilot Initiative for the reporting of a subset of CQMs that align with the Population Health goals of SIM and are also part of the MACRA QPP Program	<p>The SIM team will Conduct work sessions with providers to identify a set of CQM measures that reflect quality and should be linked to payment in a system moving from volume to value.</p> <p>The SIM team will develop a mechanism for providers to report clinical measures to Medicaid voluntarily in 2017</p> <p>Example:</p> <ul style="list-style-type: none"> • Submission of an Excel Spreadsheet to the IME • QRDA III through direct secure messaging • Submit directly to a Vendor <p>The SIM team will develop a method to incorporate CQM reporting into VBP agreements.</p> <ul style="list-style-type: none"> • In 2017 participation would be voluntary. • In 2018 providers participating in VBP arrangements would be required to report CQMs in a manner specified by the state as a trigger to VBP incentives. • In 2019 providers participating in VBP arrangements would be required to report CQMs in a manner specified by the state and meet the quality improvement threshold the baseline established by the state from the previous year's data.

SIM Goal: Establish the use of a Statewide Health Risk Assessment and Collection, Analysis, and Distribution of Social Determinants of Health Data	
Start date: 01/01/2017 End date: 01/01/2019	
Barriers to achieving this goal: Currently, stakeholders use a number of tools and ask social determinant questions in a non-uniform fashion. Data is not aggregated, analyzed or shared to support population health planning efforts.	
Mitigation: Build consensus around SDH questions across stakeholders, and embed them into existing tools while working toward implementation of a common tool	
Levers in Place to help SIM achieve this Goal: Interest across stakeholders to utilize this data to improve the delivery of their programs and health outcomes across Iowa	
AY 3 activities that will support SIM in achieving this goal:	How
Through a partnership with Wellmark, identify key SDH questions. Upon agreement, modify the Assess My Health tool to include these questions.	The SIM team will convene a group of stakeholders with Wellmark and 3M to explore the group of questions, logistics of changes that will need to be made to Assess My Health, and a process for distribution and analysis of the tool and the data obtained from it.
Through a partnership with Wellmark, explore expanded use of Assess My Health within the Healthy Hometown Program (a community-based program with a goal to improve health outcomes across specific communities).	Once the questions have been identified and the tool has been modified, its implementation can be piloted in a community to test the validity of the questions, the utility of the tool, and the usefulness of the aggregated data.
Through existing contracts, require Managed Care Organizations to modify their social determinant questions to match the questions identified through the Wellmark partnership. Require their inclusion of these questions within their existing tools and offer access to the Assess My Health tool as an alternative.	There are contract requirements in place that require each MCO to conduct a Health Risk Assessment for their patients. By further implementing this policy to motivate them to use the modified Assess My Health tool or require the use of the selected SDH questions through modifications to their own tools, we can leverage data that could be aggregated and shared to illustrate social needs in their members and incorporated into or compared to the data sets produced by Wellmark.
Require MCOs to leverage VBP contracts with ACOs to utilize AssessMyHealth. This will help fulfill managed care regulations that require MCOs to help advance at least on quality initiative from the State's Quality Plan.	The State is developing standard VBP Contract language for MCOs to use in their VBP agreements with ACOs, which will include the use of AssessMyHealth by the ACOs. The state is also adding a measure to the MCO incentive to reach a threshold of lives covered in VBP to use AssessMyHealth

Service Delivery & Care Coordination

Telehealth

Activity (telehealth functionality or activity)	Information Purpose & Location	Current barriers	Funding	Policy Levers Utilized	Fully Operational Date
Medicaid currently pays for services so long as it is consistent with the standard of practice of the provider. Payer policies may vary across the state. Iowa SIM is not pursuing expansion of Telehealth in AY 3. We are open to exploring telehealth initiatives in AY4 if identified by AY3 workgroups.					

Iowa Health Information Network

Iowa Health Information Network (IHIN), which is Iowa's statewide Health Information Exchange, is in the process of moving from state government (through the IDPH) to non-profit status; we expect that to be completed in March of 2017.

The services currently offered through the IHIN include Direct Secure Messaging, Electronic Lab Reporting, Cancer Registry Reporting, a Provider Directory, Query Functionality and Statewide Alert Notification Services.

IHIN Statistics:

757 IHIN Participation Sites:

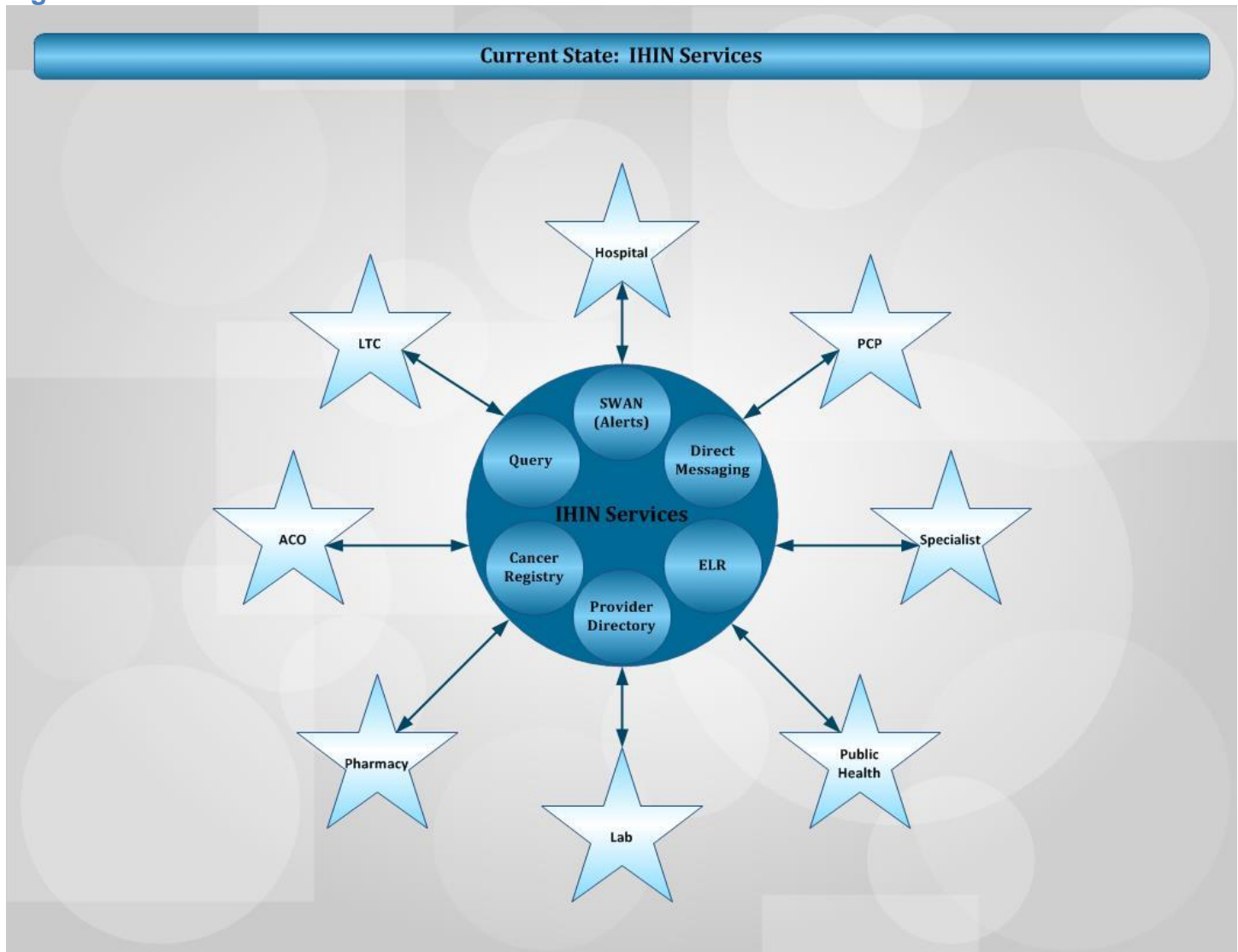
- 366 Ambulatory Practice Sites
- 117 Hospitals
- 16 Local Public Health Agencies
- 17 Long Term Care, Assisted Living or Nursing Facilities
- 166 Specialty Practices
- 75 Other Organizations

12,397 Direct Secure Messaging Accounts

26 Organizations connected to Query

Figure 5 below outlines the current services offered through the IHIN.

Figure 5: Current IHIN Services



Under 7.1.4 of the RFP for the new IHIN it states that “the designated entity (now Hielix), effective with the transfer of the IHIN, the Department shall assign and the Selected Entity shall accept, all of the Department’s rights, responsibilities, obligations and liabilities under the Department’s agreement with IME for the SWAN through the remaining years of the renewal terms of the agreement”. The Hielix Team is fully invested in continuation of the Medicaid SWAN agreement as well as the enhancing the current services of the IHIN. Figure 7 below outlines the current services offered through the IHIN.

During AY3 the new IHIN nonprofit will be convening a Board of Directors an Advisory Council and Work Groups based on guidelines in the RFP. Updates will continue to be given to these groups on the SWAN process along with updates on the IHIN. Additionally, the Hielix Team has a SIM expert as part of the team with several years of experience managing the SIM program in Minnesota. The Hielix Team is will assume control of the contract and based on their Minnesota experience, they see an opportunity to add additional professional services to not only the SWAN program but to the IHIN over all.

The new IHIN intends to make several enhancements to the professional services available, outside of SWAN, in Iowa that will improve care coordination, transitions of care and population health strategies in Iowa. It can be anticipated that the new entity will expand the available services through the IHIN in the future. These services include:

- Connecting all healthcare entities in the Iowa Healthcare ecosystem to IHIN
- ADT's from all entities in the Iowa Healthcare ecosystem to IHIN
- CCD-A exchange capabilities
- ORU messaging with observations and results
- Document managing

SWAN

Through the use of SWAN and the tools available through IHIN providers engaged in VBP are able to improve care coordination for members during critical transitions (admissions, discharges, and transfers). Improved coordination during transition has proven to reduce readmissions and improve outcomes by catching medication errors and synchronizing care plans from multiple specialty providers. Getting the right information to the right provider in a timely manner also reduces unnecessary spending within the healthcare system.

Current Statistics

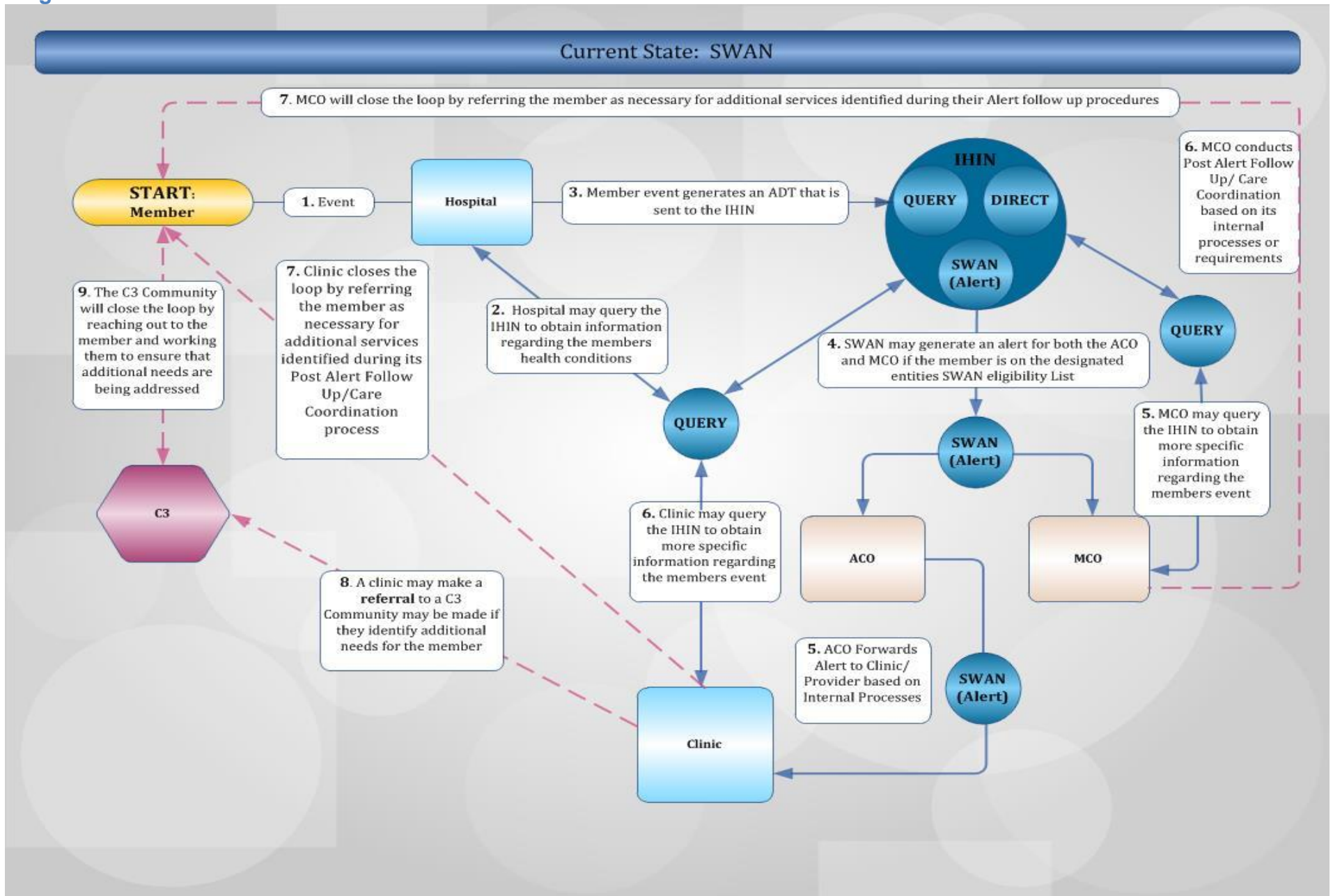
- 29 Hospitals are submitting ADT Data to the IHIN
- 2 ACOs have submitted eligibility files accounting for 125,500 members
- 1 MCO has submitted an eligibility file accounting for 195,069 members

During AY3 the SIM team activities will concentrate on educating providers and expanding the use of the tool including;

- Educating & engaging the MCOs and providers in SWAN alerts by re-enforcing understanding of the contract lever that requires that hospitals contracted with MCOs to notify the MCO of hospital admissions the same day.
- Conducting work sessions with providers to review the elements of the SWAN alerts to ensure that providers are able to meaningfully use the alerts
- Development a pilot program to engage the existing 5 ACOs to include Medicare population with expansion to members with other payers and the uninsured in future years.

Figure 6 below follows a member through the delivery system outlining each tool and step available to providers (and Payers).

Figure 6: SWAN Workflow & Care Coordination



SIM Goal: Mature the Value of the Exchange of ADT Data

SIM Goal:

Mature the Value of the exchange of ADT data

Start date:01/01/2017

End date: 12/31/2020

Barriers to achieving this goal: Potential for incomplete network and low participation of use

Mitigation: Establish the use of alerts by initially funding the system thorough SIM and piloting the expansion of alerts as use cases achieve value in the healthcare system

Levers in Place to help SIM achieve this Goal:

AY3 activities that will support SIM in achieving this goal:

How

Develop an education strategy to engage all 118 hospitals in Iowa

The SIM team will develop an education strategy to engage all 118 Iowa hospitals this strategy will include a plan to:

1. Educate and engage the MCOs and providers in SWAN alerts by re-enforcing understanding of the contract lever that requires that hospitals contracted with MCOs to notify the MCO of hospital admissions the same day.
2. Educate providers on the financial implications that tie ADT Data to VBP and the need to transform for QPP
3. Engagement of Rural Hospitals

Develop a strategy to move ADT data to “Real Time”

The SIM team will engage the leadership team at each of the hospitals submitting ADTs to ensure the understanding and need for the submission of real-time ADTs

Increase effectiveness of alerts to improve outcomes

1. Continued work with the 5 large health systems in submitting their eligibility files.
2. Continued work on the development of best practice materials for providers for implementing SWAN Alerts into their workflow processes.
3. Conducting work sessions with engaged providers to review the elements of the SWAN alerts to ensure that providers are able to meaningfully use the alerts

Develop a strategy to expand notification for services provided at non-covered entities (county jail, juvenile justice, DOC)

This item will be prioritized based on input from workgroups and survey results.

Develop a strategy to engage all 3 MCOs	<p>The SIM team will explore a plan to leverage participation of the MCO's to submit eligibility files.</p> <ul style="list-style-type: none"> • Submitting eligibility files • Receiving Alerts
Conduct a provider willingness survey (Establish Want/need)	The SIM team will develop an environmental scan to confirm the buy-in from other payers and organizations to receive alerts on populations other than Medicaid.
Develop Business processes to allow the addition of Non-Medicaid Alerts	<p>Develop a pricing structure approved by the Board of Directors or State Board Of Health</p> <p>Amend the current IDPH Contract to allow the addition of Non-Medicaid Alerts</p>
Develop a Pilot program to roll out the additional alerts	The SIM Team will develop a pilot program that will engage the existing 5 ACOs to include Medicare population with expansion to members with other payers and the uninsured in future years.

Population Health Integration

Iowans will see a more coordinated system of care through the implementation of the Population Health Roadmap and the use of Health Information Technology (HIT), by using improving capacity and infrastructure of the workforce to support care coordination.

The C3s are working to build infrastructure to support healthcare reform that requires the ability to communicate health and social needs between providers and community resources. Of the six C3 organizations, three are currently using different care coordination software systems with varying degrees of integration into other health data systems, such as electronic health records or other care coordination software. The three IT systems being used include TAVHealth, Champ software, and Salesforce. Figure 7 below shows how Health IT is integrated into Population Health activities.

Figure 7: Health IT and the integration of Population Health activities

Domains of OP Purpose & Location	Health IT functionality	Current Barriers	Funding Source	Multi-payer Policy Levers Utilized	Start Date/ Fully Operational Date
<p>Decrease preventable readmissions (beneficiaries having diabetes) from 530 to 504 by April 30, 2019. Baseline, Iowa Medicaid 9.29.16.</p> <p>Decrease preventable ED visits (beneficiaries having diabetes) from 803.2 to 763 by April 30, 2019. Baseline, Iowa Medicaid 9.29.16.</p> <p>Improvement in health care system as measured by VBP measures such as VIS</p>	<p>Data is extracted from medical claims; 3M analytics and aggregation.</p> <p>VIS: VIS Domain – Panel Health Status Change (Disease Progression)</p> <p>VIS Domain – Chronic & Follow-up (30 day post D/C, Readmission Rates, Chronic Care Visits)</p> <p>VIS Domain – Tertiary Prevention (Ambulatory Care Sensitive Acute and ED rates)</p>	<p>3M provides a quality improvement score that is derived from claims based measures</p> <p>Providers struggle with linking their quality score to clinical quality improvement activities.</p>	SIM	<p>State Purchasing/Contracting of Health Care Services: Medicaid contract with the Managed Care Organizations requires the use of 3M Analytics as a tool to inform VBP Contracting in Iowa.</p> <p>Iowa's other largest payer Wellmark also uses 3M for analytics with their ACO contract.</p>	Fully operational
<p>Decrease percentage of patients not having optimal management of diabetes from 26% to 20% by April 30, 2019 as measured by a HgbA1c>9. NQF#59</p>	<p>Iowa Healthcare Collaborative (IHC) Database populated from either 1) file sent from ACO(s) with clinics located in C3 geographical area, or 2) manual sampling of NQF measures at clinics within C3 geographical region.</p> <p>IHC aggregates data for the C3s</p> <p>Future state: eCQM database functional for health system reporting and diabetes NQF is a candidate measure for VBP.</p>	ACO DSAs not yet fully executed.	SIM	State grants: Local contracts with the C3s require reporting of specified NQF measures.	Fully operational; anticipate growth through increased reporting

Domains of OP Purpose & Location	Health IT functionality	Current Barriers	Funding Source	Multi-payer Policy Levers Utilized	Start Date/ Fully Operational Date
Diabetes Hospitalization Rate & Diabetes ED visit rate. 4 year, age-adjusted, per 100,000	Iowa Public Health Data Tracking Portal: https://pht.idph.state.ia.us/Pages/default.aspx Data extracted from multiple sources including hospitalization data, birth/death data, & census data. Data analyzed & aggregated by IDPH data integration team.	The data tracking portal continues to have new data sources added.	Federal grants		Fully operational; anticipate growth
Identify Target Population by Risk in C3 regions	Data is extracted from EHR based on parameters queried. EHR aggregates data into a patient listing. Larger health systems/ACOs have EHRs with registry/functionality for patient listing by diagnosis or risk to assure effective care coordination and disease management. Provider assessment/survey needed to determine EHR functionality.	Small clinics that are not affiliated with larger health systems may not have EHR with registry/querying by dx or risk functionality. EHR systems are limited by the functionality that the provider/organization purchased.	Health system funded	State grants: Local contracts with the C3s require Identification of target population for care coordination	Not fully operational
Clinical community linkages in C3 regions	Future state: EHR prompts are needed for individuals with newly diagnosed diabetes, Hgb A1c>9 to refer to a Certified Diabetes Self-Management Education course and to NDPP for individuals meeting risk factors from IDPH Diabetes Referral Resource. Each local referral process will be unique to that community. Upon completion of the course, the PCP would receive a closed loop referral via the IHIN direct secure messaging or another community-identified process.	EHR systems are limited by the functionality that the provider/organization purchased. New certification requirements will enhance the functionality of EHRs but the requirement on the provider to utilize/update their system is not until 2018	Health system funded	State grants: Local contracts with the C3s require Identification of roles, mapping of current referral process and process improvement technical assistance upon award.	Not fully functional. Infrastructure exists with 90 certified DSME programs across the state who routinely report into a reporting data base housed at the University of Iowa.

Iowa SIM Activities:

- Require C3s to utilize a self-selected IT system to support community care coordination referrals
- Strongly encourage C3s to use the direct secure messaging function of the IHIN to ensure closed loop referrals.
- Identify and provide resources, as they become available, to C3s that provide ideas and guidelines for information sharing between the health care delivery system and community-based organizations
- Communicate routinely with other state initiatives using similar IT systems

Figure 7 & 8 below illustrates the referral processes that are being implemented between to improve care coordination and identification of SDH needs within a C3.

Figure 8: C3 Referral Process - Primary Care Provider

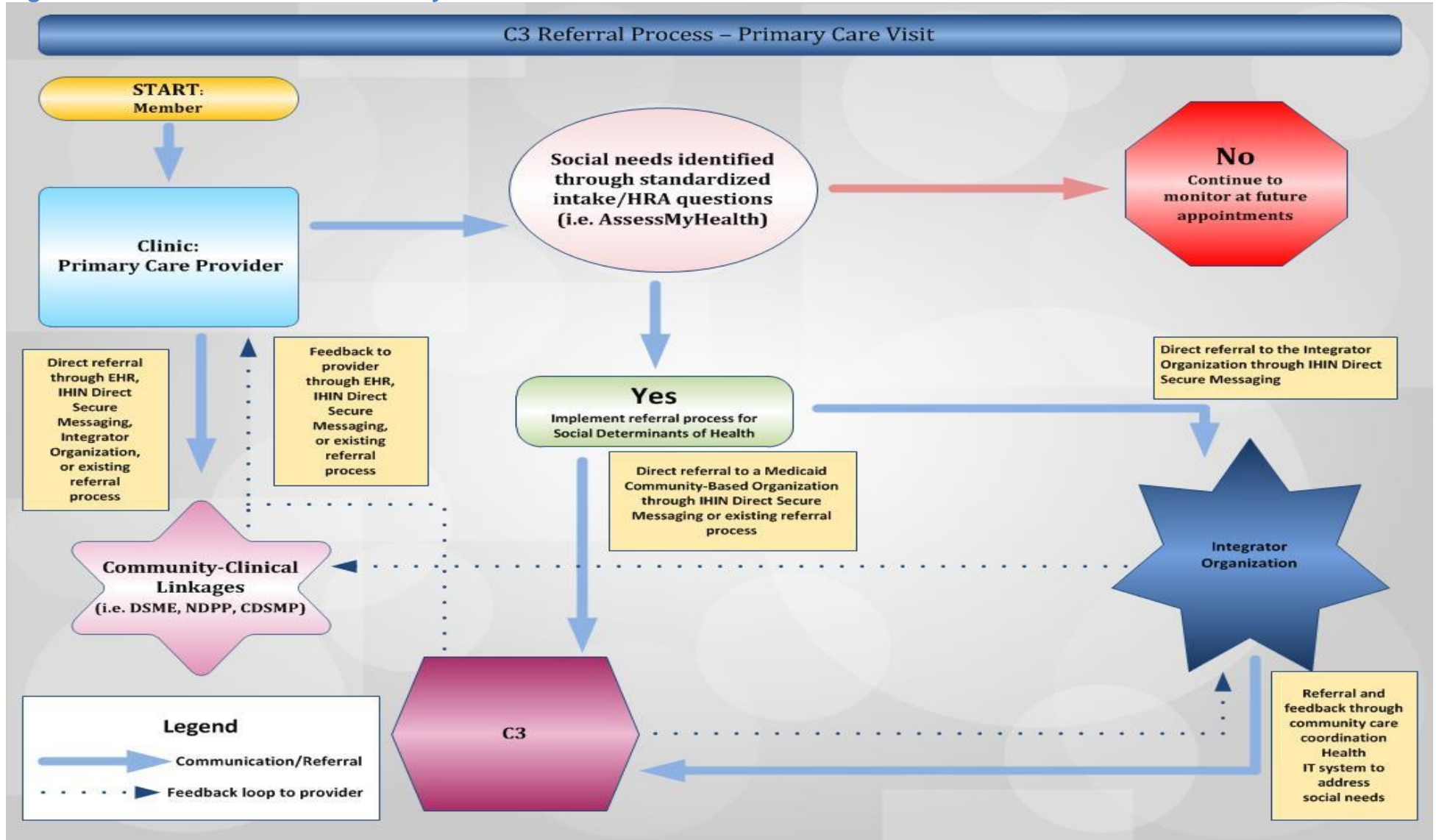


Figure 9: C3 Referral Process - Community Based Organization

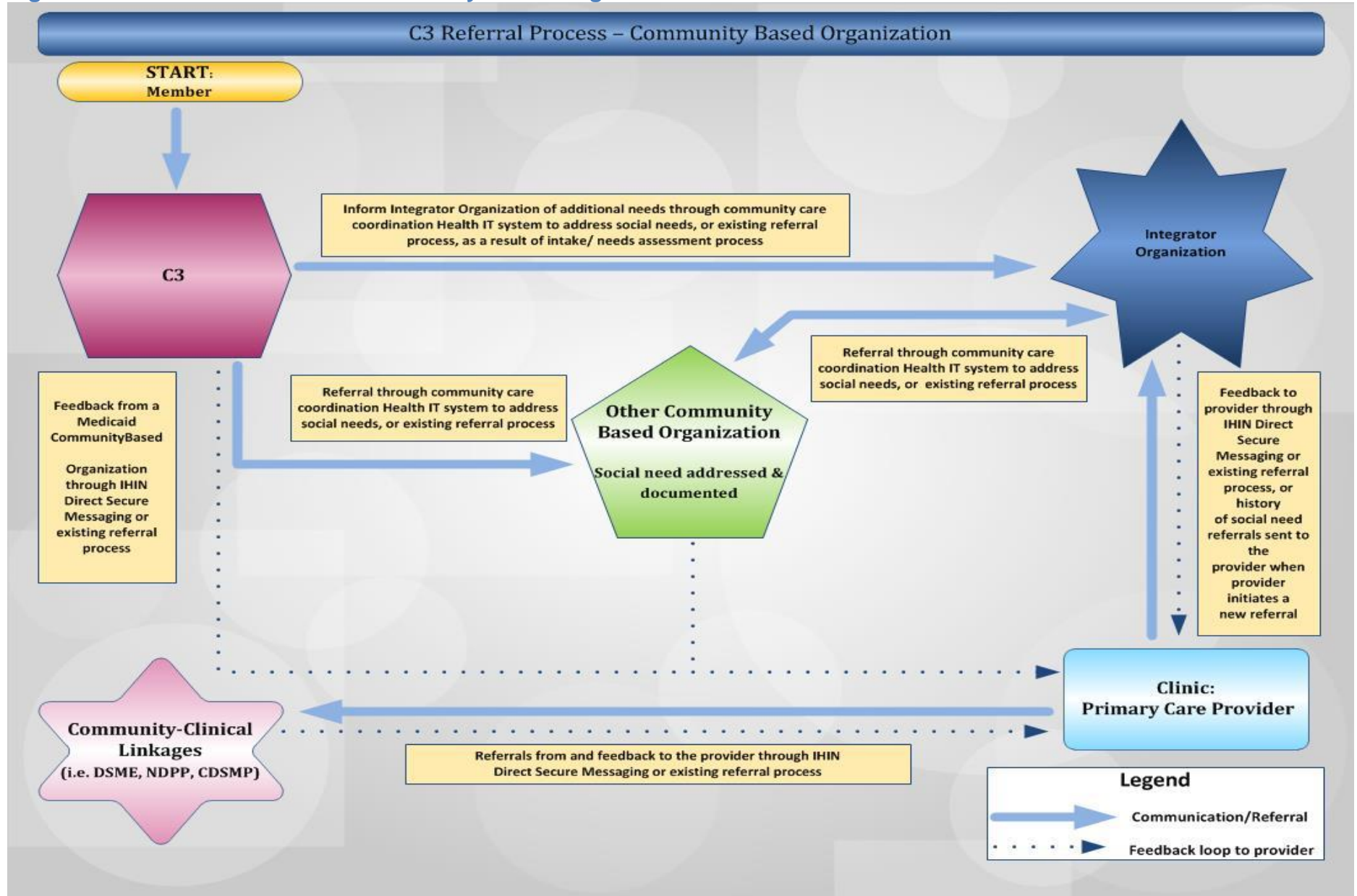
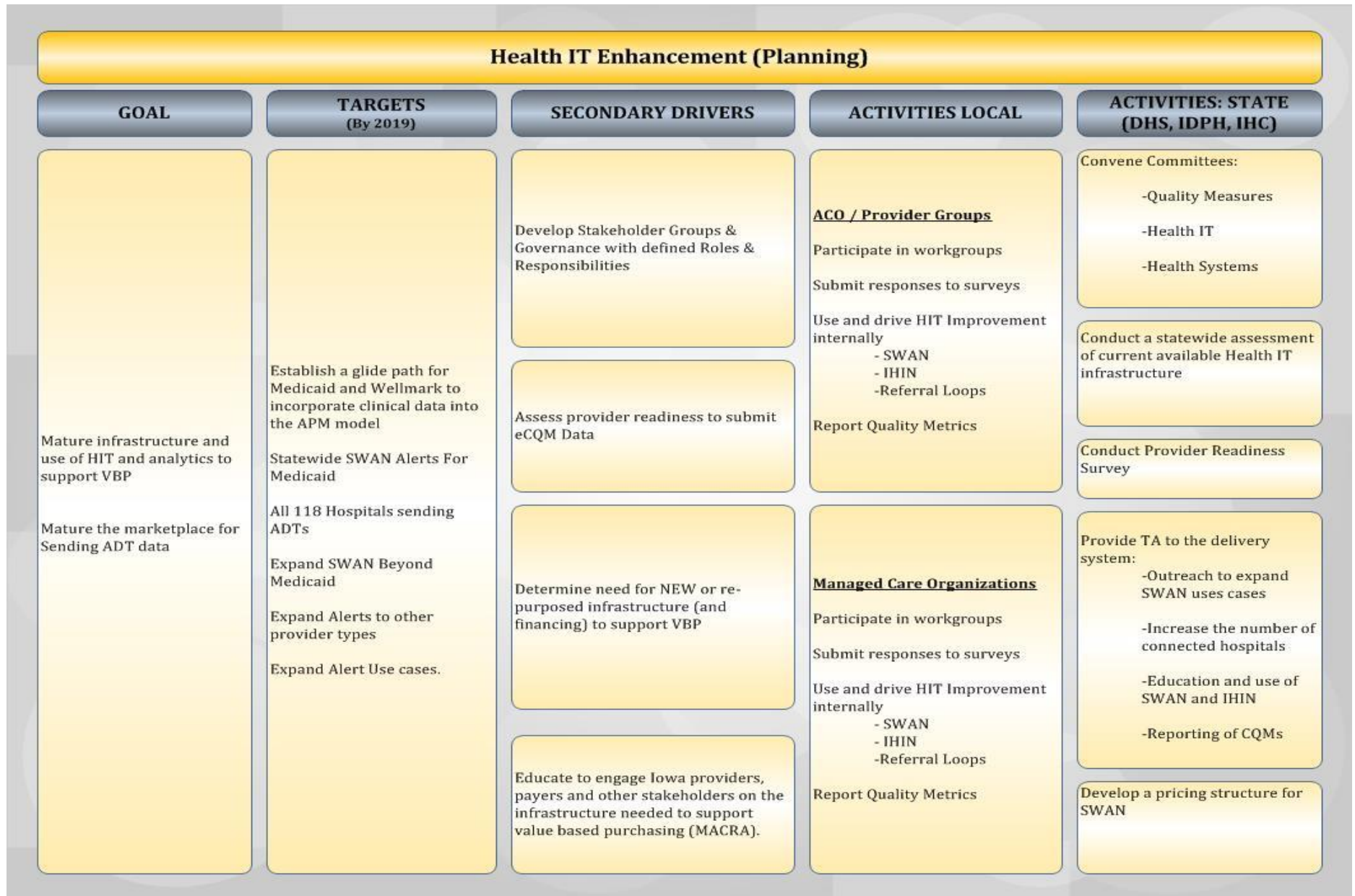


Figure 10: Health IT Driver Diagram



HealthCare Delivery System Technical Assistance - SIM Data Portal

The SIM team will provide technical assistance to the delivery system through the use of Webinars, Statewide Learning Events, and Website updates. Topics will include:

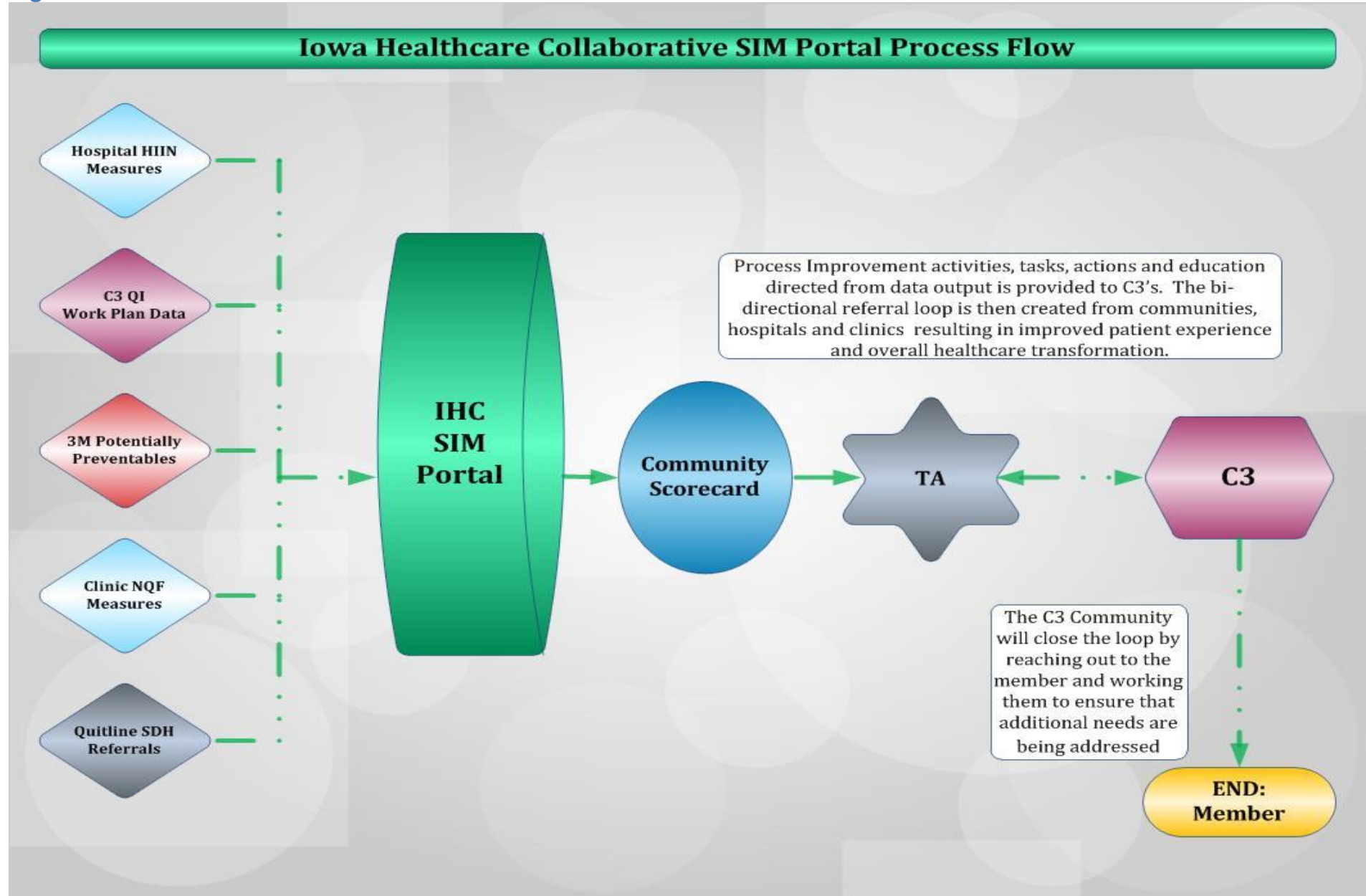
- Community Scorecards that assist in process improvement
- Education on the use of IHIN and SWAN
 - Use cases and best practices
 - Work sessions with engaged providers to review the elements of the SWAN alerts to ensure that providers are able to meaningfully use the alerts
 - Query and Direct Secure Messaging
- MACRA and the Quality Payment Program including the importance of collecting Clinical Quality Measures

Through data collected from the below inputs, specific Technical Assistance will be developed around Process Improvement activities, tasks, actions and education.

- Hospital level, facility specific (HIIN) data from 20 participating hospitals
- Clinic level NQF measure from 6 clinics that are part of the current C3 communities.
- C3 community specific measures
- Quitline community specific referral numbers,
- 3M population centric Potentially Preventable Measures

AY3 will bring data from partner organizations that provides qualitative monitoring and evaluation for service providers and community members statewide.

Figure 11: IHC SIM Portal



Health IT Enhancement Milestones

SIM Activity: HIT Implementation Planning				
Milestone/Measure of Success	Budget Activity	Action Steps	Timeline	Responsible Party
Develop Workgroup for HIT Planning	IDPH SOW 3	Identify HIT Workgroup Membership Create Guiding Documents, MOU, Charters, R&R	June 2017	IDPH
Assess the Current state of Health IT	IDPH SOW 3	Conduct a Statewide Assessment of Current HIT Infrastructure Data Collection ability Data Aggregation ability Analytics Reporting Services Financing Governance Sustainability Share the Results of the HIT Assessment	September – December 2017	IDPH
Identify System-Wide CQMs	IDPH SOW 3	Inform HIT workgroup of System-wide VBP Framework Identify a Core Set of CQMs that Align with the System-wide VBP Framework Develop Value Propositions & Use Cases Conduct a HIT Provider Readiness Survey Provider EHR Certifications & Capabilities Barriers to Data Extraction from EHRs Financial Barriers Workflow Barriers Share Results of Provider Readiness Survey Identify Readiness Gaps and Develop Strategies to Address	September 2017- February 2018	IDPH & Workgroup
Educate Iowa Providers on the use of Health IT and Analytics to Support VBP and MACRA Alignments	IDPH SOW 3	HIT and Analytics for VBP presentation on a Statewide Learning Event Agenda Conduct at least one Webinar on HIT and Analytics for VBP Publish a Website Resources on SIM pages for HIT and Analytics	March – April 2018	IDPH
Refine Definition of Quality Measurement for Medicaid Pop	IDPH SOW 3 & IME	Identify a Core Set of CQMs that Align with Population Health and SIM Initiatives	January 2018	IDPH & IME
Pilot Reporting CQMs to Medicaid	IDPH SOW 3 & IME	Identify Mechanism that Providers will Use to Report CQMs for APMs Submit Test File for CQM Pilot Program	March – April 2018	IDPH & IME

Summary

As outlined in the implementation plans above the Iowa SIM team has defined the steps necessary to pursue the development of Health IT infrastructure to equip Iowa providers for Payment and Delivery System Reform. Much of AY3 will be spent planning, identifying and developing the Health IT infrastructure and processes needed going forward. Integrating data from external providers, such as electronic medical record (EMR) data and hospital discharge data, using health information technology (HIT), health information exchange (HIE), and Electronic Health Records (EHR) capabilities are being specifically explored and the development of work groups that will meet regularly to formulate the plan for long term goals for Health IT Infrastructure in Iowa is already underway. As we move through AY3 findings from the provider readiness survey and Health IT inventory will help Iowa to identify the additional Health IT pieces needed to reach our goals.